Thank you for registering for the Boston College Recreational Day Camp. Attached you will find all of the necessary forms and informational sheets for your child to attend camp this summer. We ask that you send all Watermarked forms to the Member Services office at the Flynn Recreation Complex by 5PM on June 22nd. The included documentation is necessary for the health and safety for your son/daughter while attending the BC Recreational Day Camp. Campers will not be permitted to attend without this information.

Even if a form does not seem relevant to your camper, please write N/A on the form and complete the signature portion.

The Immunization History form can be completed by your child’s physician.

Forms to be completed and returned to the Member Services office:
- Camp Waiver Form
  - Physical Examination/Medical History Form &
    - Immunization History Form
  - Authorization to Administer Medication Form
  - Camper Pick-up Authorization Form

Informational sheets for parent/guardians reference:
- Question & Answer for Parents Sheet
- Meningococcal Disease Information Sheet
- Swine Flu Parent Information Sheet
- Camp Parking Map

Mail to: Boston College Recreation Day Camp
Flynn Recreation Complex
140 Commonwealth Ave.
Chestnut Hill, MA 02467

Fax: 617-552-1886

If you have any further questions concerning camp please do not hesitate to contact the Member Services office at 617-552-0797. More camp specific details will be sent out as the start date approaches.

Sincerely,

Camp Staff

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Boston College - Campus Recreation
Member Services Office
140 Commonwealth Avenue
Chestnut Hill, MA 02467
Tel (617) 552-0797
Fax (617) 552-1886
Boston College Recreational Day Camp
Waiver Form 2016

The named camper ________________________ has my permission to participate in the camp program. In case of an emergency, I understand that every attempt will be made to contact the emergency contact listed below. If contact is unsuccessful, I give permission to the attending physician to render medical treatment to the participant, including (if necessary) hospitalization. Any expense arising from injury is the responsibility of the person signing below.

The Health History provided is correct to the best of my knowledge, and the child described herein has permission to engage in all prescribed program activities except as noted by the examining physician and me. I hereby authorize the staff of Boston College to provide care that includes routine diagnostic procedures (i.e. x-rays, blood and urine test) and medical treatment as necessary to my minor son/daughter _________________________. I understand that the consent and authorization herein granted does not include major surgical procedures and is valid only during the camp/clinic.

Please list physical conditions that the clinician should be aware of (allergies, recurring illnesses, injuries, disabilities, chronic illnesses.)
Date of most recent tetanus immunization: ___________________________________
(If more than 10 years ago, a shot is recommended.)

Accident insurance for the “year” Boston College “sport” “Camp/Clinic” is provided by Boston College on an excess basis. All registrants must have their own primary medical insurance. Any medical costs and expenses will be the primary responsibility of the parent or guardian’s medical coverage.

I, the undersigned parent and/or legal guardian of the participant listed above, do hereby consent to his or her participation in the program identified above. I, as the parent of the participant and on behalf of the participant, release, hold harmless and agree to indemnify Trustees of Boston College and each of their respective members, partners, officers, directors, faculty, staff, representatives, affiliates, employees and agents, as applicable, from and against any present or future claim, loss or liability for injury to person or property which I or the participant may suffer, or for which the Participant may be liable to any other person, related to their participation in the program (including periods in transit to or from the participant’s destination), resulting from any cause, including but not limited to ordinary or gross negligence.

Model Release - BY SIGNING, I GIVE BOSTON COLLEGE (BC) PERMISSION to record my image, likeness, and/or voice for use in its print and Internet publications or productions, including advertising, signage and promotional materials. I also give BC permission to use my name, academic class standing and major in any accompanying caption, if applicable. I agree that the photographs and videos are the property of BC and hereby release BC from any and all claims that I may have from its use of my image or voice.

Name of Camper (Please print): ________________________________
Health Insurance Company: ________________________________
Health Insurance Policy #: ________________________________

Name of Parent/ Guardian (Print): ________________________________
Signature of Parent/ Guardian: ________________________________ Date: ____________

Emergency contact: ________________________________ Relation: ______
Emergency phone: ________________________________ □ Home □ Work □ Cell
Physical Examination/Medical History Form
Boston College Recreational Day Camp
2016

Please Complete BOTH Sides of Form

Please Print

FORM WILL NOT BE ACCEPTED
WITHOUT PHYSICIAN’S SIGNATURE

LAST NAME: ___________________________ FIRST NAME: ___________________________

DATE OF BIRTH: ___/___/______ AGE: ______ SEX: ______

HOME ADDRESS: ________________________________________________________________

CITY: ___________________________ STATE __________ ZIP CODE __________

PARENT/GUARDIAN 1: ___________________________ RELATION: ___________________________

HOME PHONE: (______) _______________ WORK PHONE: (______) _______________

CELL PHONE: (______) _______________

PARENT/GUARDIAN 2: ___________________________ RELATION: ___________________________

HOME PHONE: (______) _______________ WORK PHONE: (______) _______________

CELL PHONE: (______) _______________

HEALTH HISTORY
Please fill in dates where appropriate.

Illness
Frequent Ear Infections
Heart Defect/Disease
Convulsions
Diabetes
Bleeding/Clothing Disorders

**Asthma

***Allergies
Hay Fever
Ivy Poisoning
*Insect Stings
Medicine
Foods
*What Insects

***If Epi-Pen is required to handle allergic reaction, family must supply one.

Operations or serious injuries (with dates):
Chronic or recurring illness:
Any specific activities to be restricted?

Name of Campers Dentist?
Name of Campers Doctor?
Name of Medical Insurance Carrier:

Address: ___________________________ Phone ___________________________

PARENT/GUARDIAN AUTHORIZATION: MUST BE SIGNED FOR CHILD TO PARTICIPATE IN CAMP

This Health History is correct so far as I know, and the child described herein has permission to engage in all prescribed program activities except as noted by the examining physician and me. I hereby authorize the staff of Boston College to provide care that includes routine diagnostic procedures (i.e.-x-rays, blood and urine test) and medical treatment to my minor camper. I understand that the consent and authorization herein granted does not include major surgical procedures and are valid only during camp.

Parent/Guardian Signature: ___________________________ Date: ___________________________

Print Name: ___________________________
# IMMUNIZATION HISTORY AND DATES

<table>
<thead>
<tr>
<th>DPT 1. _________</th>
<th>Polio 1. _________</th>
<th>MMR (combined) 1. _________</th>
<th>Meningococcal (not required) 1. _________</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. _________</td>
<td>2. _________</td>
<td>2. _________</td>
<td></td>
</tr>
<tr>
<td>3. _________</td>
<td>3. _________</td>
<td>3. _________</td>
<td></td>
</tr>
<tr>
<td>4. _________</td>
<td>4. _________</td>
<td>4. _________</td>
<td></td>
</tr>
<tr>
<td>(Td)*5. _________</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>History of Chicken Pox</th>
<th>HIB 1. _________</th>
<th>Hepatitis B Series</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>2. _________</td>
<td>(only for children born on or after 1/1/92)</td>
</tr>
<tr>
<td>Date</td>
<td>3. _________</td>
<td>1. _________</td>
</tr>
<tr>
<td>No</td>
<td>4. _________</td>
<td>2. _________</td>
</tr>
</tbody>
</table>

*Td Booster Required for children of age 12 or older.

## Medical Examination

- To be filled in by a licensed physician.
- This examination should be performed within one calendar year of arrival at the Boston College Camp.
- Examination for some other purpose within this period is acceptable

**Code:**
- V-Satisfactory
- X-Not Satisfactory (explain)
- O-Not Examined

<table>
<thead>
<tr>
<th>Code</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ht.</td>
<td>Wt.</td>
</tr>
<tr>
<td>Eyes</td>
<td>Lungs</td>
</tr>
</tbody>
</table>

Allergy: Please describe degree of allergic reaction:

<table>
<thead>
<tr>
<th>Glasses</th>
<th>Contacts</th>
<th>Abdomen</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ears</td>
<td>Hernia</td>
<td>Head (Concussion)</td>
</tr>
<tr>
<td>Nose</td>
<td>Genitalia</td>
<td>Extremities</td>
</tr>
<tr>
<td>Throat</td>
<td>Posture (spine)</td>
<td>General Appraisal</td>
</tr>
<tr>
<td>Heart</td>
<td>Cardiovascular Disease</td>
<td>Skin</td>
</tr>
</tbody>
</table>

**Current Medications**

- Special Diet
- Musculoskeletal Injuries (explain)
- Any Specific activities to be restricted?

I have examined the person described herein and have reviewed the health history. It is my opinion that this person is physically able to engage in program activities, except as noted above.

Examining Physician: ___________________________ Date: ____________

Please Print Physician’s Name: ___________________________ Phone: ____________
AUTHORIZATION TO ADMINISTER MEDICATION TO A CAMPER
By parent/guardian - Please read even if your child does not require medication

Parents Please Note: The camp staff would prefer, whenever possible, that prescription medication be administered outside of camp hours, under the supervision of a parent/guardian. However, if your child does need to take medication during camp hours, please read the following information and fill out the authorization form and the necessary information on the back of this form.

AUTHORIZATION FOR SELF-ADMINISTRATION OF MEDICATION

My camper, ___________________________ (name of child), may be offered sunscreen. I am aware that I must provide any specific sunscreen my child may require.

My camper, ___________________________ (name of child), requires the use of an inhaler. I am aware that my child may use his/her inhaler when he/she requires it during the duration of camp.

AUTHORIZATION TO ADMINISTER MEDICATION

I hereby authorize ___________________________ (name of camp) to administer, to my child, ___________________________ (name of child) the medication(s) listed on the back of this form in accordance with the following regulations:

• Prescription medications shall be kept in original containers bearing the pharmacy label, which shows the date of filling, the pharmacy name and address, the filling pharmacist’s name, serial number of prescription, name of patient, name of prescribing practitioner, name of prescribed medication, directions for use and cautionary statements (if any). If medication is in the form of tablets or capsules the container should be labeled with the number of capsules. Prescription medications should not be brought to camp in “baggies” separate from the original container.

• Medication will be administered by the health supervisor or by a licensed health care professional authorized to administer prescription medications. The health supervisor is not a health care professional authorized to administer prescription medications, the administration of medications shall be under the professional oversight of the health care consultant.

• When no longer needed, medications shall be returned to the parent/guardian whenever possible. If the medication cannot be returned, it shall be destroyed.

Name of Parent/Guardian ________________________________________
Signature of Parent/Guardian ___________________________________ Date ________
PARENT/GUARDIAN MUST FILL OUT THE BACK OF THIS FORM

Medication Information

Name of Camper: ___________________________ Age: ________ Parent/Guardian Name: ___________________________

Food/Drug Allergies: ____________________________________________ Home Telephone: __________________________

Diagnosis (at Parent’s discretion) _________________________________________ Business Telephone: __________________________

Name of Licensed Prescriber: ____________________________________________ Emergency Telephone: __________________________

Name of Medication: ____________________________________________ Dose Given at Camp: ____________________________ Route of Administration: ____________________________

Frequency: ____________________________ Date Ordered: ____________________________ Duration of Order: ____________________________ Quantity Received: ____________________________

Expiration date of Medications Received: ____________________________ Special Storage Requirements: ____________________________

Specific Instructions (e.g.- on empty stomach/with water): ____________________________

Specific Precautions: ____________________________

Possible Side Effects/Adverse Reactions: ____________________________

Other medications (at parent’s discretion): ____________________________
Camper Pick-Up Authorization
Boston College Recreational Day Camp
2016

Mandated by Massachusetts State Law 105 CMR 430.159(B), please provide a list of the individuals who will be authorized to pick-up the named camper. No camper will be released to an individual who is not listed. In case a change is needed, a phone call must be made to the Member Services office at (617) 552-0797 before 1:00 PM on that day.

CAMPER’S NAME (please print):____________________________________________________

Parent/Guardian’s Names (please print):___________________________________________

Parent/Guardian’s Signature:____________________________________ Date:____________

Parent/Guardian’s Phone #___________________ □ Home □ Work □ Cell

Parent/Guardian’s Email: ________________________________

Authorized Individuals other than Parent/Guardian above (please print):

1. Name _____________________ Phone #__________________ □ Home □ Work □ Cell
2. Name _____________________ Phone #__________________ □ Home □ Work □ Cell
3. Name _____________________ Phone #__________________ □ Home □ Work □ Cell

Individuals NOT Authorized to pick up the named camper (please print):

1. __________________________
2. __________________________
3. __________________________

*My son/daughter will be attending extended day: Y N

Please call if any special cases arise, (617) 552-0797